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FOR MAXIMUM MARGINAL CORRECTION . . . **THE AO TILLYER FAMILY OF LENSES**

THE RETINOSCOPE AND ITS VALUE TO OPTOMETRISTS*

by George B. Ruby, O.D., D.O.S.
Member of the Faculty of Northern Illinois College of Optometry

Recently, in an optometric publication, an optometrist made the statement that he would rather throw his retinoscope out of the window than fail to receive a certain optometrical publication. The publication in question is a very valuable medium of information and is one which this writer also holds in high esteem, but if anything is to be thrown out of the window, perhaps it would be better to select something involving a little more of a sacrifice to the optometrist personally—like a pipe or a cigar—and not something which may work a hardship on the patients who depend on the optometrist for eye comfort. It was this statement which caused the writer to make a recapitulation of the retinoscope as it is, and can be used, in o ptometry. Perhaps the retinoscope was thrown out because it is not doing all it may do, and therefore it is in order that a review of the possibilities of the retinoscope shall be given. The review of retinoscopic practice is given by the writer, as based upon personal experiences of daily practice.

Let us imagine a situation which probably occurs frequently to any practicing optometrist.

A waiting room has a number of patients waiting rather impatiently for their opportunity to be received in the examination room, with one or more having entered without appointments. The practitioner may have the feeling that if he delays too long, some of the waiting patients may become restless to the point of leaving. Now is the time to discover whether you are going to slight that 21 point examination technique and rush through your work with just a subjective so as to take care of the unexpected arrivals. To a certain extent it is possible to make reappointments, but even then the new cases need a quick, accurate analysis of the situation—a visual survey—so as to give a probable prognosis, and thereafter a reappointment is usually accepted without question. As an example, suppose that into a rather filled waiting room comes a mother with a 6 year old boy and the boy starts to raise a disturbance so that your work is bothered, even in your private office. What are you going to do? Will you let him tear up the office until his turn, or is there an easy and yet good way to handle this case? I give you my solution.

I will reappoint and excuse for the day the patient with whom I have been occupied and do this at the earliest possible moment, for I know that my own quality of work is lowered when I am bothered. Then I take the source of annoyance into the office, take a quick history, and find if possible, the reason why the patient came to me. Frequently the child will be cross-eyed and frequently he has had "drops" put into his eyes by the last examiner and he is making a disturbance because he dislikes the "drops" and therefore also dislikes the man who uses the "drops". Now I put the child in the chair and give him a hydraulic chair ride. Next I have a small blue light located at 20 feet and I light that and ask him to please watch it and tell me if it "goes out". We are now ready for a retinoscopy finding and I swing the phoropter in front of his eyes and supply enough *base out* prism over the eye which is to do the seeing so that I can look into the eye without cutting off vision of the blue light for the seeing eye.

The *base out* prism will also perform another function of great value which we shall describe later. Complete the static retinoscopy and thereafter determine the vision. Often you will see the eyes straighten, and you are now in a position to definitely assure the parent that there are distinct possibilities of straightening the eyes. Or if the "drop" finding was well made and the eyes are still not straight, you

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can demonstrate this point. In either event the child has learned that here is a doctor who does not hurt him, and he has had real fun in his hydraulic ride up and down and in the game with the blue light. You can now tell the parent that you want a reappointment at a definite time when you can go further into the case and also to check your present findings, and there will be little difficulty in having the reappointment accepted. All of this work can be performed in a very few minutes, and you are clear again to take on the regular line of patients. *But* you must know your retinoscope and have complete confidence in your ability to use it. Therefore this discussion deals with suggestions for the improvement of retinoscopy technique.

To perform a good retinoscopy using a phoropter (a phorometer can be used in the same way), the writer finds the following details of operation are essential, with consideration in this paper being given solely to static retinoscopy.

(a) For fixation by the patient use a blue light at 20 feet distance. The advantages of this light are that:

1. Blue light is relaxing to a tense nervous system.

2. Blue light requires less accommodative effort to obtain a focus and therefore it is physically a relaxing agent.

3. A blue light bulb has little critical detail, and therefore little focalizing effort is called forth by the patient.

The writer's instructions are just to watch the blue light and take life easy, but do not go to sleep. If the pupillary diameter decreases during a retinoscopy, it is the time to chide the patient that he is not relaxing and thus you are able to exercise patient control, because you know that with a constant light intensity, if the pupil constricts accommodation has come into play.

(b) Learn to tilt the phoropter either up or down, or to one or the other side, so as to get rid of the troublesome reflections of the phoropter lenses, but be careful not to throw the instrument off level. By this action you may now get a view of the pupil which is to be scoped with complete freedom from reflection interference from the lenses.

(c) Study the conditions under which the first Purkinje image is formed, using the retinoscopy light as the light source. The image is the small bright image which is always seen practically in the center of the pupil if you cover one of the patient's eyes. Ask him to look at the light with the one remaining eye and you look through the observer's hole in the retinoscope to see this image. It is also the same image as is used in operating the opthalmometer.

Now if we desire an accurate retinoscopy result it must provide proper refractive power for the macular area, not for the peripheral area of the retina. Therefore retinoscopy must have a guarantee that when it is performed the eye which is being scoped is so located that light enters and leaves the eye on the fixation axis. But the first Purkinje image, if located in the center of the pupil, is a practical guarantee that light is entering and leaving on the optic axis, and the optic axis is seldom farther than 4° deviation from the fixation axis. Therefore, get the first Purkinje image of the retinoscope light in the center of the pupil as you look through the observer's hole and you have taken a location such that light can be said to be falling on the macular area and is reflected therefrom and used as the basis of your lens selection.

At first this method of operation may seem difficult to obtain, but if you will be careful in using *base out* prism on the seeing eye, you will soon find that the procedure is very simple and rapidly performed and thereby the vision of the seeing eye is not cut off by the operator's head. If during the examination, the Purkinje image shifts you know at once that operating conditions are bad and no further work should be done until the image is properly located again.

The benefits of this procedure are at least two-fold, viz:

(1) Most of the "scissors" motions are completely eliminated and this type of reflection is probably the most frequent source of retinos-

copy difficulties, and the most baffling and time-consuming.

(2) Refractive results are usually very close to the No. 7 findings so that in practice you can always nearly plan to obtain 20/20 visual acuity if it is to be had.

(d) The writer has both streak and spot type of retinoscope always at hand, but after much practice with both, the spot type appears to be preferable for fast accurate results. However, the writer's technique differs slightly from standard spot technique and therefore we must now consider this feature of the examination.

To build up a dependable retinoscopy technique, the writer suggests that the optometrist make his Fisher's schematic eye do much of the work, and the method is this: Take the schematic eye and remove it from its base. Go to any watchmaker and obtain a tin lid from a watch movement case which will just fit over the eye ring of the phoropter as the paper sanitary cups do. Make a circular hole about 10mm. in diameter in the center of the lid. Now solder the tin eye cup to the lens holding studs of the artificial eye, and you are ready to perform retinoscopy on your phoropter without any patient being needed behind the instrument.

In the back of the artificial eye put a normal fundus picture, and set the artificial eye at random without looking to see what the setting may be and you will be started in your technique of refracting an eye which is either hyperopic or myopic. Now remember that you must first and always have the first Purkinje image in the center of the pupil, and begin your practice with a 5mm. pupil in the artificial eye. Next remember that the troublesome reflections can be avoided by swinging the instrument as previously described. You are now ready to add plus lenses until the motion is "against" and the eye is now fogged. Reduce the plus power until a blood-red fireball appears in the center of the pupil, while the periphery of the pupil still shows the silverywhite of the "against" motion and you have the neutral point.

Do *not* swing the spot of light clear across the pupil, but keep the light spot always on the pupil and use small swinging motions. You will find later when you work with human eyes that this method is superior in that the eye being scoped soon becomes light-adapted to the constant illumination and the pupil enlarges and makes work easier. On the other hand if the light is swung clear across the pupil, the eye is alternately adapted and not adapted to light; the patient is annoyed and the pupil is small.

Work with as dim a light as is practical for a given eye and the patient on whom you are to use this technique will thank you for your consideration. He will also be in better shape for the subjective work which is to follow.

As a check on your neutral point, which the writer finds is best done at 26 inches, or arm's length, move in a trifle closer and the blood-red fireball in the center of the pupil is larger. Move farther away and the fireball disappears. Now at arm's length rotate the light spot slowly in a small circle, with constant pupillary illumination and you will see that the fireball also goes around in a circle *with* the light while the silvery white goes around always *against* the light. This means that it is rising while the red spot is dropping, and it is moving to the left when the light and the red spot are going to the right, etc.

(e) If you will now neutralize ten unknown settings in this artificial eye until you are perfect in your work with spherical settings, then you are ready to perfect your technique with cylinders. But always remember that the working distance must be deducted from the lens powers selected to give neutrality, and that the net result should correct the ametropia as shown on the indicator scale of the Fisher eye.

For cylinder practice, gather up a number of old discarded ophthalmic lenses and see that they slip easily into the lens studs of the Fisher eye. Do not mark the cylinder or the power, so that at all times in your work you are working with unknowns. Now place one of these lenses in the studs and remember that a plus lens of any nature makes the eye a plus eye and a minus lens makes a minus eye.

The Fisher eye must now be set at zero, so that all of the ametropia found in retinoscopy will be due to the lens.

A plus eye is a myopic eye and will be corrected by minus lenses in the phoropter; while the minus eye is a hyperopic eye and will be corrected by plus lenses in the phoropter.

Now add plus lenses slowly until the white reflex is seen in one meridian. Note that meridian and start counting the plus addition thereafter (in quarter diopter amounts) until the opposite meridian now shows "against" motion or white reflex. This count will tell you at once how many quarter diopter additions of minus cylinder must be given and the axis is the second meridian which was neutralized. When this cylinder is thrown into position, neutrality shown at once will be manifest and the red reflex should run around in a circle as the light area is made to rotate. A check should be made for the strength of the sphere just as previously, and then the test is done, except that the deduction for working distance must be made. Always before a retinoscopy is complete on a patient he should be fogged and unfogged until the red fireball of neutrality is seen.

If you will conscientiously practice retinoscopy by this method as laid out, you will find that you acquire a new feeling of strength and ability to handle quickly and accurately those hard cases where the eye is amblyopic, or where there is a squint, or when there is a particular rush in the day's work. Your patients will better recognize your ability when you are able without asking for a subjective, to give 20/20 visual acuity. In your subjective you will find that the retinoscopic objective test was so valuable that in any questions in your subjective work, you will be leaning constantly (and rightfully so) on the results of your retinoscopy. Finally, in cases where the subjective differs radically from the retinoscopy results, it is proper to quickly place a 1.5 D. lens in front of the subjective lens, call for the blue light fixation and find whether the patient's subjective work does give a good reflex or not. This last practice is especially good in cases of very high error, where the subjective reactions of the patient appear to be indecisive and unreliable.

It is the hope of this writer that this resume

(*Please turn to page* 11)

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From the Editor . . .

At M.S.O. two problems that have normally received less attention in the past have become acute because of the unusually large lecture classes. Although some may think that attention in the classrooms and cleanliness throughout the school are insignificant, we believe that we speak for the majority of the students when we say that these conditions are now of definite importance.

Without exception we know that every student in class is an offender against classroom attention. We do not refer to the small amount of talking that is concerned with the material being presented, but rather to the chatter about subjects of no consequence. Almost every instructor at school has allowed us the privilege of talking quietly in the belief that his material is being discussed. Recently, however, this incessant babbling and murmuring has overflowed its normal barriers and is making it extremely difficult for some of us to comprehend the material presented. In some of the lectures, in fact, it is almost impossible to hear what the instructor is saying. To be sure, the privilege of talking quietly in class has been over-ridden. But more important, you have taken advantage of your fellow students. For those who are having difficulty your babbling is only adding an extra obstacle. This extra noise is surely not fair to them, our instructors or yourselves.

By the time we reached college, we have surely attained the necessary maturity to conduct ourselves as gentlemen. The trouble is that being human, we make errors. On the other hand, as intelligent human beings, we surely know how to rectify a wrong. We have abused the privilege of talking quietly in class; now let us be intelligent and correct our misdoing.

Although each class is conveniently provided with containers for waste paper and the halls are dotted with receptacles for cigarettes, it is not uncommon to see the floors of the school used instead. Certainly none of us would litter up the floors of our homes. Surely then, we should have the good taste to apply the dictates of our home life at school. You do not have to be a basket ball player to be able to flip a cigarette butt into a receptacle or a lunch bag into a container. You just have to be a gentleman.

It will only be through VOLUNTARY action of the entire student body that the prevalent babble in classrooms and the general disregard for cleanliness will be eliminated. By correcting these two conditions we can make the school not only a better place to study in but a better place to learn.

M. I. and E. W.

OPTOMETRIC PATHOLOGY

SOLAR CATARACT

by Arthur Bruce

In examining eyes we sometimes come across cases of lenticular opacity due to excessive light or heat—the condition known as Insolation Cataract or Solar Cataract. It is often referred to as Cataract from Tropical Light or Cataract from Excessive Heat. It includes the typical cataract of glass-blowers and electric cataract, both of which are believed due to the bad effects of intense artificial light and heat on the crystalline lens.

It has been stated by Robinson that the crystalline lens itself, acting like any strong convex lens, will concentrate the rays of any intense light to which it may be exposed at the nodal point, and this brings about the acquired form of posterior polar cataract, characteristic of all forms of cataracts due to excessive illumination.

This explanation has not been proved, but a theory of this kind seems to help account for the large number of cataracts found in India and other tropical and semi-tropical climates which are due to the fierce rays of the sun.

Other observers cannot agree on this theory, because in Martinique and Egypt, where the conditions are somewhat similar, and in Norway, where winter dazzle and glare are excessive, cataract is uncommon.

However it may be with natives in hot countries, one explanation offered for cataract in workmen exposed to intense heat and light is the hydration of the intra-ocular albumens under the influence of the water of the aqueous humor and the long-continued excess of light and heat.

Sometimes the term "Electric Cataract" is used to denote lenticular opacities induced by *intensity* of light and in particular by its *ultra-violet* rays; the term "cataract from intense light" is probably more definite.

Modern refractive techniques have demonstrated the need for "uncommon" lens devices. Where significant factors indicate a large number of patients better satisfied, the refraction more successful—the "uncommon" becomes the "common".

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Omega Epsilon Phi

by Milton Gallin

This past month the fraternity has devoted paramount attention to the problems and program of the newly-formed membership committee, which is expected to take care of all problems pertaining to the freshmen. Also sharing the spot light was the division of the program committee into several groups covering different activities such as sports, membership, lectures, evening meetings and entertainment, to alleviate individual burdens and facilitate more widespread participation. Fraters Gerlan and Robinson will handle the sport department, while Brothers Sarkin, Bram, Mandel, Schaeffer and Berger will have their work cut out in the membership committee.

Accepting the proposal for an Inter-Fraternity Council, President Wilson has appointed Brothers Saltz, Abrams and Galloway to represent O. E. Phi. It will be their job to make inter-fraternal relationships more cordial and to eliminate conflicting social functions.

On Monday, September 13, the drawing for O. E. Phi's Philco portable radio was held at a short noonday meeting. Dean Green drew the winning number, which was held by Miss Louise Masaili of 40 Federal Street in Beverly and by now the radio has been presented to her by Brother John Sloan. After drawing the winning number Dean Green was observed tearing up his ticket stubs—better luck next time!

Later that same Monday afternoon, our fraternity trounced the P. O. S. men in a softball game to the tune of 10 to 6. Rumors have it that the P. O. S. boys threw the game to cement interfraternity relations. It is this reporter's belief that the boys are "hustling" for bets for the next game and will be importing "ringers" to ensure a win—they sure need help from somewhere! Nevertheless, the game marked the beginning of what we hope will be a continued series of such activities. Gathering from all the shouting and laughter, everybody would be wise to attend the next fracas.

(*Please turn to page* 11)

Junior Jabs

Joseph Barresi, '49

The school outing at beautiful Crane's Beach was a huge success. Greater attendance could have made it even better, but everyone there had a swell time and that's what really counted. One of the humorous quips of the day was made during a game of touch football—a small voice from the sidelines of the makeshift gridiron piped up with, "Did you fall again, Daddy?", and Bob Brownsword slowly uttered, "Yup", to his small son.

Our class softball club has cinched its sixth straight win over the sophomores thanks to the great managing and shortstopping of Dr. "Mitch". Okie O'Connell continues to dart around the "hot corner" of third base making things miserable for all batters. Stewart still snags everything in and out of normal reach as he guards first.

Clinic assignments are now in vogue and the men in white are finally refracting real live out patients. As we peek into the dressing room, we find the men jumping into their whites, chewing Sen Sen, renewing old 'scope batteries, wiping that last spot from their shoes, and some even dragging a comb through their thinning locks. Suddenly a roar, backfire and slamming of tin doors echoes from Newbury St. to Commonwealth Ave. via the clinic windows, and we come to the conclusion that Hank Wilson has just missed being marked late again.

The character of the month seems to be found in Norwood's one and only (we hope) Eddie Holman. This personality, I have found, actually eats his own chicken pie dinners. He is an antimetrope and it follows that he is an alternating suspender (he also wears a belt). Eddie's wife has a toilsome time getting him to wear shoes, but his better half wins out—and therefore, he is never seen without them. His plans for the future include buying a helicopter—reason?—obvious, no fenders to dent. All in all, though, Eddie is the favorite of all

(*Please turn to page* 11)

Ramblyopia

by I. C. Best, D.Occ.

Among the great strides made by experimental optometry in recent years, none stands out more prominently than those in the field of Ramblyopia. Today Ramblyopia, or wandering of the eyes, is no longer believed to be a morbid, degenerative, or traumatic condition, although some of its symptoms have suggested such etiologies to earlier investigators. Josephus Lindus Naso, more intimately known as "Black-eyed Joe", having made the greatest advances in the field, has come closest to touching upon the real cause—Bella Femina. Although his work has not been all-embracing, he has nevertheless recorded the following classification for posterity: Bella Femina

Family—Anybody's.

Group—Social, of course.

Genus—They sure do; especially the better dressed type with the hour-glass shape, ensheathed in sheer vestments, causing the more violent reaction.

Species—Some do and some don't, but a unique universal language prevails.

Phylum—Always, in a little black book.

It has long been known that under the influence of solitude, the eyes will tend to assume many forms. It is just when such a form enters the field of vision, becoming the object of regard, that the chain of symptoms characterizing Ramblyopia are set off.

First, there is a spasm of the major skeletal muscles and a sharp inhalation of breath followed by spasmodic whistling or some such vocalized exhalation which favorably compares with the call of a wolf or primeval man. The eyes gleam, fixating quickly and accurately; the palpebral fissure opens wide; and the eye lids may open and close simultaneously or unilaterally without ever relinquishing visual fixation of the desired object. In many cases it has been scientifically noted that the accommodation becomes flexible, overcoming existing refractive errors. Stereopsis and speed of recognition are noticeably high, with an over-all appearance of a condition of the eyes resembling exophthalmus or kerato-conus. In extreme cases, the patient has been known to stalk rapidly in the direction of his gaze and try to overpower the object of regard. In others, the spasm is followed by complete relaxation and languor; the deviation of the eyes simulates that of an amorous bovine; and a marked euphoria and a broad self-satisfied smile are present. These victims are of no use to anyone for 15 minutes after receipt of the first visual impressions.

Affecting the sympathetic nervous system, the heart-beat will be rapid with an accompanying hypertension, with enlargement of the left ventricle quite possible, and an extra systole is noticed rather often.

Ramblyopia is known to show no mercy or distinction for social status or physical condition, attacking the rich and the poor, as the strong and the weak; age is but a nominal barrier. It is apt to raise its lovely head at any place, at any time and after any kind.

The treatments proposed have been many and varied, as well they might be since Rampblyopia is a response rather than a pathological condition. Some have advocated physiotherapy, ranging from a brisk slapping of the victim's cheeks to a cold bath. Others have tried isolation, on the theory that ramblyopia is an allergy. Still others have maintained that separation of the sexes (Ed. Note: NO! NO!) until the afflicted individuals arrived at years of discretion would appear a sound treatment, but this method failed when it was learned that no such years exist and that in many cases the discretionary powers decrease with age. Several authorities, not only medical but parental and connubial, proposed such restraints as opaque spectacles, or complete occlusion of the eyes, but in those cases the necessity for the initiation of the Braille System has led to even more dire results.

Trying too desperately to overcome the effects of the disease has often led to extravasation of blood from the nose, lividity of the subocular facial tissues and even the loss of front teeth, requiring extensive orthodontia. It is at this point that we can safely state that marriage appears most incompatible with ramblyopia, since most of the time the male of the

species suffers from a two-way attack; apparently this specimen has never found out how to deceive two of the people some of the time.

As we ourself have suffered chronically from this condition and have carried out prolonged studies of it, we feel that we are in the position (Yup, the view from here is fine. Will you take a look at those well turned . . . Oh, pardon the interruption, just where were we? Oh yes, treatment recommended.) We have found out that this strange condition is largely nervous in nature, and that the best treatment is a soothing and relaxing one. Warm baths being somewhat awkward to arrange and against our better principles, we prefer a gentle massage; a soothing hand on the brow, slipping down to the nape of the neck; a blonde head cuddled on the - - - - -er, er (Will you look at those two!)—and it has been said that if the brunette (It is good advice to have an odd assortment of six around, because the more there are, the quicker the patient will be cured —or killed) will hold the victim quite closely for some time to alleviate tremors, and will apply osculation, we can guarantee the effects to be quite satisfactory to all concerned.

Our investigators have gone beyond that last point many times in their effort to find the complete cure for Ramblyopia, but somehow it has always been impossible for us to obtain coherent reports right after the treatment was obtained, therefore we shall have to refer the kind reader to Dr. Kinseys' next book. (Wait a minute, buddy, wait a minute—remember, the redhead's mine!!)

Retinoscopy

(*Continued from page 6*)

of retinoscopy has proved of interest and profit to the reader, and at some future date it may be possible to give added hints regarding the great value of the retinoscope to the optometrist. As a parting suggestion, if you desire to be *really* good in retinoscopy, after you are perfected in the art of using a 5mm. pupil then repeat the practice with a pupil 1.5 mm. in diameter and you will be ready not only for the children with their large pupils, but also for the presbyope with his pin-point pupil.

Junior Jabs

(*Continued from page 9*)

his classmates, and when his new baby daughter gets to know him, he'll be her favorite too, we're sure. Congratulations, Doris and Eddie.

LENS CHIPS:

Congratulations to Lillian and Ed Plonowski on the arrival of their new daughter. The days are getting shorter—the proof of the matter is that Parent, on arising in the dark of the morning (for a practical optics class), put on one black and one brown shoe. Needless to say, he found out too late and was the center of attraction and guffaws for the rest of that most embarrassing morning. FLASH—ST-37 sales have risen 5 thousand percent in the last two weeks. Orchids go to Barnes for adeptly explaining the difference between the horizontal and vertical lines of the astigmatic chart to his first patient. Also to Jablow for recovering my identification bracelet in 5 feet of water at Crane's Beach. The cross cylinder tests for the add, men, is worth its weight in gold. I know —my first patient was a presbyope.

Well, four closing words will suffice—GOOD LUCK IN EXAMS! See you next month. . .

O. E. Phi

(*Continued from page 9*)

On Friday evening September 17, O. E. Phi held its annual freshman smoker at the Hotel Gardner, at which the freshmen were introduced to the fraternity, the faculty, and each other. The details of this occasion will appear in our next column.

It appears as though there are better days ahead for the fraternity. With President Wilson's wife going to work, Secretary Farland may hopefully look forward to receiving the sorely needed loose-leaf notebook—with paper —in which to keep the minutes. With Brother Galloway's wife following suit, he can now afford his own ice-cream cones and stop mooching. Now's the time to get back at him, boys!!

O. E. Phi extends its congratulations and best wishes to Brother and Mrs. Planowski on the birth of their daughter.

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